TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ORTHOTEXAS PHYSICIANS AND SURGEONS

Respondent Name
ALLEN ISD

MFDR Tracking Number
M4-17-3277-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JULY 11, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT 29999 is an unlisted code used because there is no code for arthroscopic knee knotchplasty. This should be paid since it is supported by the operative note."

Amount in Dispute: $1,800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Respondent's Supplemental Position Summary: "Carrier maintains its position as outlined in the original response."

Responses Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 14, 2016	CPT Code 29999 Unlisted Procedure	$1,800.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.1, effective March 1, 2008, provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 96-Non covered charge(s).
   - P5-Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.
   - CPT 29999 is not a valid code, resubmit with a valid CPT code to accurately describe procedure.
   - W3-Additional payment made on appeal/reconsideration.

Issues

1. What is the applicable rule for determining reimbursement for CPT code 29999?
2. Is the respondent's denial of payment supported?
3. Did the requestor support the amount sought for code 29999 is fair and reasonable?

Findings

1. The disputed services are subject to the fee guidelines outlined in 28 Texas Administrative Code §134.203.

2. According to the explanation of benefits, the respondent denied reimbursement for CPT code 29999 based upon reason codes: "96-Non covered charge(s)," and "CPT 29999 is not a valid code, resubmit with a valid CPT code to accurately describe procedure."

   28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   28 Texas Administrative Code §134.203(b)(1) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   On the disputed date of service the requestor billed CPT codes 29855, 29880 and 29999. These codes are defined as:

   - 29855-Arthroscopically aided treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation, when performed (includes arthroscopy).
   - 29880-Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed.
   - 29999-Unlisted procedure, arthroscopy.

   The requestor noted "CPT 29999 is an unlisted code used because there is no code for arthroscopic knee knotchplasty."

   The 2016 CPT code book does not list a code for arthroscopic knee notchplasty.

   The Operative report indicates "notchplasty was performed along the lateral border of the notch decompressing the ACL and then removing the anterior osteophyte…"

   The division finds the respondent's denial based upon reason code "96" is not supported because the report supports widening the lateral border of the notch.

3. The requestor is seeking $1,800.00 for code 29999. A review of Medicare's fee schedule finds no relative value unit or payment has been assigned to code 29999; therefore, this code is subject to 28 Texas Administrative Code §134.203(f).

   28 Texas Administrative Code §134.203(f) states "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)." Medicare does not assign a relative value or payment fee schedule for CPT code 29999; therefore, reimbursement is in accordance with §134.1.

   28 Texas Administrative Code §134.1, requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care

network shall be made in accordance with subsection §134.1(f) which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought of $1,800.00 for CPT code 29999 would be a fair and reasonable rate of reimbursement. As a result, payment is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		8/9/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.